

## JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035147

FILED VS SEP 20 1960

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 443

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE IOWA b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE		c. CITY OR TOWN LAMONI	
Length of stay in 1b D.O.A.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. INDEP. SAN. & HOSP.		d. STREET ADDRESS (If outside, give location) NONE	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lyla Middle BUCY Last		4. DATE OF DEATH Month September Day 12 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1933
9. AGE (last birthday) 27		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (City and state or country) MT. AYR, IOWA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME EUGENE CLOUGH		13b. MOTHER'S MAIDEN NAME VIOLA REASONOR	
14. NAME OF HUSBAND OR WIFE RAY E. BUCY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO	
16. SOCIAL SECURITY NO.		17. INFORMANT EUGENE CLOUGH, TINGLEY, IOWA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerosis, resulting from ruptured</i> <i>liver &amp; spleen, multiple rib fractures, multiple</i> <i>fractures of pelvis, bones, sacrum and lower ribs.</i> <i>Multiple lacerations of colon &amp; small intestine</i> DUE TO (b) <i>...</i> DUE TO (c) <i>...</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>car truck collision</i>	
20c. TIME OF INJURY Hour 11:04 p.m. Month, Day, Year 9-12-60	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. CITY, TOWN, OR LOCATION JACKSON IOWA	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>SWR Toole, M.D., coroner</i>		22b. ADDRESS 6627 Market St S.W.	
22c. DATE SIGNED 9-13-60		22d. DATE RECD. BY LOCAL REG. 9-13-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 9-13-60	
23c. NAME OF CEMETERY OR CREMATORY LILLY CEMETERY		23d. LOCATION (City, town, or county) LAMONI, IOWA	
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. 9-13-60	
26. REGISTRAR'S SIGNATURE <i>James H. Toole</i>		27. REGISTRAR'S SIGNATURE	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, IN

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.